

Janet Moore  
Credentialing Specialist  
Provider Enrollment Department



**CIGNA HealthCare**  
**Medicare Administration**

P.O. Box 25226  
Nashville, TN 37202-5226

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**Sample**

DEAR \_\_\_\_\_ :

Welcome to the Medicare Part B Program. Your application has been processed and approved. Listed below is information on how we processed this application. **Please verify that all information is correct.**

Provider Name: **DR.** \_\_\_\_\_  
Performing Provider Number: \_\_\_\_\_  
Unique Physician Identification Number (UPIN): \_\_\_\_\_  
Legal Name Associated with Number: \_\_\_\_\_  
Group Pricing Number: **N/A**  
Doing Business As: **N/A**  
You are listed for billing as: **A Sole Proprietor**  
The Payee address is: \_\_\_\_\_  
\_\_\_\_\_  
The Practice location is: \_\_\_\_\_

Effective Date: **09/01/2004**

You are listed as a participating provider.

You have been set up to submit claims electronically at this time.

Please notify our office immediately at 1.866.520.4007 if any of the above information is incorrect. Also, remember that all state privilege taxes must be kept current. We look forward to working with you in the future.

Sincerely,

*Janet Moore*

Janet Moore

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